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ABSTRACT

The paper examines the nature of child abuse and neglect, considers its effects on the emotional well being of the child, and describes treatment approaches. Emotional neglect is differentiated from emotional disturbance. Long-term effects of child maltreatment include irreversible physical damage to the central nervous system, emotional damage, psychological trauma, and variations in child development. Research is cited on 12 psychological characteristics of abuse/neglect, including failure to thrive, neurological dysfunction, impaired speech and language, hyperactivity, withdrawal, socially deviant tendencies, learning disability, and suicide. Intervention and treatment for the infant and preschool child are explored, including therapeutic preschools, crisis intervention, foster care, parent education and psychotherapy, and self-help and support groups. Signs of change for children (such as increased attention spans and increased interest in people) and parents (improved self-image and friendship) are pointed out. (CL)

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PREVENTING EMOTIONAL DISTURBANCE IN ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES THROUGH EARLY INTERVENTION

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April 27, 1982

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ABSTRACT

Among children-in-conflict are those whose environments are in conflict with their physical, developmental, and emotional needs. These children include those who are chronically abused or neglected. Numerous studies are cited in this paper which demonstrate both the short and long-term psychological effects of maltreatment of young children and infants by their caretakers. These include maladaptive behaviors; variations and deficits in the child's course of development; irreversible physical damage to the child's central nervous system; characterological deviance; low achievement; delinquency; violent behavior.

Commonalities that characterize abusive parents are: unfulfilled needs for nurturance of their own; fears of relating; lack of support systems; life crises; inability to care for a child; constant external stresses from poverty, illness, and family discord.

Successful early intervention with abused and neglected children results in profound behavioral changes in the child and greater success in school. Maladaptive interaction patterns between parents and children are replaced by more nurturing, less violent, and more effective means through various counseling or education programs. Among these are "enriched foster care;" early intervention with high-risk infants; home health visitors, or visiting lay therapists; therapeutic preschool or daycare; psychotherapy; and parent-education and self-help groups. In all of these modes of treatment, the focus is upon family involvement and outreach. The child and parents must be treated simultaneously and assertively. Clients cannot always be expected to come for help; it is the professionals and agencies who do the reaching out.

It is encouraging that, with appropriate early intervention, as many as 80% of abusing and neglectful families can be substantially helped, and in many cases, turned completely around. Numerous projects are now reporting high success rates when the intervention is well-coordinated and starts early enough. The tragedy of life-long emotional disturbance from early maltreatment can clearly be prevented. Early intervention is far less costly than the long-term cost of special education, foster care, and the juvenile justice system.

"The children who hate, we must remember, are the children of neglect. They have been chronically traumatized, through repetitive frustrations of many of their basic needs. Indeed, we might speculate that they suffer from a disease entity directly stemming from neglect itself, which might be called "neglect edema." Their frustration swells, and festers, as it were, until even frustration, which is minor and painless, in terms of the "normal" becomes for them an intolerable challenge to control which they cannot meet. For each frustration, no matter how small the issue may be, is lumped together with the frustrations of the past."

--- Fritz Redl, Children Who Hate, 1952

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INTRODUCTION

A holistic approach to the understanding of "children in conflict" begins with these basic tenets:

1. Emotional disturbance in a child is the result (and continuing cause) of non-functional interactions of the child with his environment.

2. Early non-functional interactions of the child with his/her primary caretakers (usually the parents) have profound repercussions upon the rest of the child's life.

These assumptions form a backdrop for the development of the subject of this paper: the long-term psychological effects of early abuse and neglect of the child, and the reversal or diminishing of these effects through early intervention.

DEFINITIONS

The following definitions of abuse and neglect were provided by the Monroe County Department of Social Services:

"The abused child is a child less than 16 years whose parent or guardian: 1. a.) inflicts or allows to be inflicted upon the child physical injury, by other than accidental means, or b.) creates or allows to be created a substantial risk of physical injury to such child, by other than accidental means, which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ; 2.) commits, or allows to be committed, a sex offense against such child."

"The neglected child is a child less than 18 years, whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the parent or guardian to exercise a minimal degree of care."

According to Kempe (1972), the term "battered child" was coined in 1961, for a seminar sponsored by the American Academy of Pediatrics, and was intended to "shake" pediatricians out of their complacency regarding the problem. The term was intended to encompass the total spectrum of abuse and neglect. It is not frequently used in more recent literature, however, since it apparently has done the

job it was intended to do. Physicians and the general public now appear to be at least aware of the existence of the problem, although there is not generalized agreement as to prevention and treatment.

Lelila Whiting (1976) defined emotional neglect as:

"1. the inability of meaningful adults to provide the necessary nurturance, stimulation, encouragement, and protection of the child at various stages of development which inhibits optimal functioning.

2. emotional neglect is a result of subtle or blatant acts of omission or commission experienced by the child which causes handicapping stress on the child, and is manifested in patterns of inappropriate behavior."

INCIDENCE OF CHILD ABUSE: AGE OF CHILDREN INVOLVED

According to numerous sources, child abuse has reached epidemic proportions in our society. It is a major cause of death in children under two. Every year, 1,000,000 children are injured by their parents or guardians. In 1979, 2000 children in the U.S. died as a result of neglect or abuse. The American Humane Society has estimated that within the next ten years, 50,000 children will die from battering, and approximately 300,000 will receive permanent injuries.

Gelles (1978) and Galdston (1965), both cited in Armstrong (1981), have shown that pre-school age children are more vulnerable to abuse than older children. Castle (1972) cited studies that indicated, "the younger the child, the more likely it is to be injured and the more serious the injury is likely to be."

An average of 235 cases of child maltreatment per month are reported to the Monroe County Dept. of Social Services. Of these, approximately 80% are founded. These statistics reflect only in part the children who are psychologically damaged as a result of the trauma of physical, verbal, emotional, and/or sexual maltreatment.

CONFLICTS WITHIN AND WITHOUT

In order to begin to understand the long-term psychological effects of maltreatment, it is useful to examine the extent to which

the abused or neglected child fits into the definition of "children in conflict." Reinert (1976) described the children where the conflict is not within the child, but within his/her environment:

"Many children are encountering moderate to severe disorders in their daily activities, not because of their behavior, but because of the situation in which they find themselves." (p. 5)

Redl's (1965) hyperresilient children are those who should not be labeled "emotionally disturbed", but who must confront severely psychopathological life experiences, such as severe maltreatment by caretakers. Redl differentiates between the emotionally disturbed child (whose conflicts are within), and the child whose behavior indicates a state of emotional disturbance (whose conflicts are without.) The latter child's "emotional health or characterological development is in some jeopardy." The strong implication is that something must be done to remove the danger, and that if this does not happen, the child can suffer permanent emotional disturbance. However, as will be seen, neither Redl nor any other researcher or clinician in the literature will venture to specify exactly how much damage is too much, and how soon intervention must begin in order to prevent long-term psychopathy.

Differentiating Emotional Neglect from Emotional Disturbance

In an article published in Children Today in 1976, Leila Whiting offered what amounts to an operational definition of "emotional neglect" that may shed some light on this discussion, as well as indicate some of the broader implications for treatment. The writer indicated that it may be the caretakers' responses that differentiate "emotional disturbance" and "emotional neglect." If parents demonstrate a willingness and ability to carry through and seek appropriate help for their child's persistent inappropriate behaviors, and to then effect a change in the total environmental situation, then it may be we are dealing with a case of emotional disturbance (within the child.) If, however, parents are reluctant to acknowledge the problem, resist appropriate help, and refuse to act to ameliorate the problem with their child, then emotional neglect is more likely to be operating. While this definition implies the assumption of parental guilt, it does have the effect of mobilizing help for the

child. By using the term "neglect" rather than "disturbed" the situation becomes reportable and society must then actively protect the child. It implies that some type of intervention can and must be found.

The term "emotional disturbance" then implies a state of being existing within the child that cries out for specialized treatment. "Emotional disturbance" can be viewed as a product of neurological disfunction, of environmental deprivation or trauma, or whatever combination of determinants that may never be known, but are operating in any given child. Emotional neglect implies an on-going process, which society may or may not be able to stop, depending on the individual case. It nevertheless cries out for intervention once the neglect is discovered, or even for prevention, if we can determine children at risk for emotional neglect.

Emotional neglect and disturbance, in summary, are inextricably intertwined even in their definitions, and even more likely, in reality, for any given "child in conflict." The bottom line may be a difference in our philosophy of society's relative involvement in families around the issues of child-rearing, as much as differences among families in accepting or rejecting help. If we believe unshakably in the rights of children, then we are more likely to make observations of emotional neglect, unless the child can be shown to have been different biologically from the start. If we believe in the rights of parents to bring up children as they choose, then it is more likely that we will see the emotional disturbance as existing within the child. Since reality is on a continuum and does not come in mutually exclusive categories, it is essential to mark off the point on the continuum where this paper's philosophy will primarily rest. The holistic approach demands that both the child and the parents be taken into account in the delicate process of growing up - that either or both can succeed or fail. However, since children are relatively more vulnerable than adults, this paper will put greater stress on the failure of the parents and the larger society, and the rights of children to have the most conducive and healthy environments possible.

OVERALL LONG-TERM EFFECTS OF CHILD MALTREATMENT

Martin (1974) examined four potential long-term effects of maltreatment on abused children. These effects arise not only from the abuse itself, but also from the circumstances giving rise to it, and the therapeutic measures intended to correct the situation, but often exacerbate the problem, such as multiple foster homes. The types of long-term damage include: 1.) irreversible physical damage to the central nervous system as a result of injury, malnutrition, or confinement of movement; 2.) emotional damage resulting from the psychological climate in the child's family; 3.) psycholcgical trauma resulting from the removal of the child from the abusive environment; and 4.) variations in the child's course of development, and psychic equipment.

In a recent British study, Trowell and Castle (1981) concluded in a refreshingly simple statement:

"Using broad categories, it is alarming to find that almost all the abused children were emotionally disturbed and in need of some form of help, so that even if the abuse does not recur they remain with considerable problems. There was a small but important group that were so disturbed that without help, one could confidently predict major psychiatric illness as they grow up . . .

"Many of these children have survived physically, but as has been shown, have suffered severe emotional damage. Essentially, if we break the chain of deprivation, our services should be aimed at helping the children of today, who are the potential parents of tomorrow, to be able to communicate with, and understand the needs of, their own children."

PSYCHOLOGICAL CHARACTERISTICS OF ABUSED/NEGLECTED CHILDREN

For the purposes of the paper, "psychological characteristics" will consist of the behavior and abilities normally expected at any given developmental level, and the deviance from those expectations. For example, in the infant, we are concerned with failure-to-thrive, and in the adolescent, with truancy and juvenile delinquency.

The following is a list of some of the psychological characteristics associated with maltreated children in various studies, starting in 1945:

1. failure-to-thrive; "hospitalism"
2. neurological disfunction
3. retardation
4. deficits in motor abilities
5. impaired speech and language
6. maladaptive behaviors (short-term)
7. hyperactivity; impulsivity
8. withdrawal
9. characterological deviance
10. socially deviant behaviors; violent tendencies
11. low school achievement; learning disability
12. suicide

A general overview will precede a more in-depth examination of each of these characteristics. Kline (1975) examined the educational and psychological problems of 138 school age abused children. They found that these children were more likely than controls to be placed in classes for the educably retarded and emotionally disturbed, to be placed in psychiatric institutions, to have psychological problems, and to achieve lower academic scores.

Elmer and Gregg (1967) examined the developmental characteristics of abused children. They followed-up on 20 children who had been the victims of assault or gross negligence. Their results indicated that many of these children exhibited signs of mental retardation; emotional disturbance in varying degrees; speech problems; and physical defects related to their injuries. Only two were normal in all areas, as far as could be determined. While abuse was the sole cause of the physical defects in one-third of the children, the other problems may also have resulted in part from prematurity, maternal deprivation, and cultural child care practices, as well as the explicit mistreatment.

Failure-to-Thrive: "Hospitalism"

While the failure-to-thrive syndrome can occur throughout childhood, it's most commonly diagnosed in infants. It refers to a serious growth disorder, in which the infant, upon admission to hospital, is below the third percentile in growth, is emaciated, frantic, difficult to sooth, and eats voraciously. (Bullard, et al., 1968; Kempe, 1978). Patton and Gardner (1963) described a group of

these infants as retarded in growth, lethargic, avoiding contact with other people, and displaying limited motor activity. They typically displayed a fixed stare, or "radar gaze." Among the 6 infants in this study, these children had in fact received adequate nourishment at home, but had not been touched or talked to by their mothers. At least one parent in each family was described as emotionally disturbed.

In partial contrast, a study by Pollitt, et al. (1975) revealed that mothers of failure-to-thrive infants did not show signs of severe psychopathological behavior. Significant differences emerged only in terms of a reduction in physical affection and verbal interaction with the children in the failure-to-thrive infants.

Togut et al., (1969) found that in nine cases of failure-to-thrive, all had mothers with normal IQ, but signs of high levels of anxiety, insecurity and guilt, and were overwhelmed by family responsibilities. These children improved in the hospital, but slowed upon return home. The characteristics of 54 infant neglect cases that ended in death were cited by Trube-Becker (1977). The infants were emaciated; had dry, puckered and scaly skin; a lack of subcutaneous fatty tissue; and an aged face. In every case, the family lived in extremely poor financial and social conditions, and the mothers were very young, with no preparation for mothering.

Failure-to-thrive infants were first described among institutionalized children (Goldfarb, 1945; Bakwin, 1949; Mitchell, 1963.) These infants showed a high mortality rate even though their physical needs were met. Other symptoms included loss of apetite, listlessness; delay in infancy vocal and smiling behavior; unresponsiveness, which was attributed to emotional deprivation and lack of sensory stimulation. Infants given the most attention on the ward or those removed to responsive homes before 3 or 4 months of age, recovered rapidly. Goldfarb (1945) compared institutionalized infants suffering from extreme deprivation of stimulation to infants reared in foster homes, as equated pairs, at ages 3, 6, 8, and 12 years, and found the following characteristics in the deprived group: basic defects in total personalities, problems in concept formation, passivity and emotional apathy, hyperactivity, and disorganization, aggressive behaviors which lacked a goal-orientation. Mitchell (1963)

also reported retarded motor, language, and social development, and an early lack of interest in toys; though after the first year, the child preferred objects to people.

It was, in fact, this early research of institutionalized infants that led to the theory of a psychogenic causality for autism: i.e., a sensory deprivation in the early days of life leads to the inability to relate to people. While this theory has largely been discredited, there is some evidence that infants who are handled often by their mothers have stabler dispositions, interact better with others, and develop a greater range of responses than infants who are left to "cry it out" (Salk, 1968).

Abused Infants

Goldson, et al. (1976) examined the medical records of 140 children discharged with the diagnosis of non-accidental trauma, or failure-to-thrive, and found the following characteristics: 1.) most children were under 3 at the time of the incident; 2.) the birth-weights of the abused children were lower than the non-abused, suggesting that the mother-infant separation that often occurs with low birth-weight infants may disrupt the bonding process and predispose children to abuse; 3.) white children were more often abused than non-white, which could reflect the lack of support systems in the white population; 4.) most were preventable injuries; 5.) the abuser was the biological parent in 70% of the cases; 6.) both married and single individuals abuse; 7.) more hospitalizations occur in spring and fall months.

Infant abuse has been linked to the ill-health of both mother and child (Lynch, 1975, cited in Kempe, 1978). Lynch emphasized that parental expectations may be dashed at the moment of birth, and that ill-health during pregnancy, prolonged and difficult labor and delivery, congenital malformation, birth injuries (especially brain damage), and prematurity are all associated with increased potential for abuse. The separation of infant and mother creates further stress, and prevents the formation of a strong maternal bond. "The child is a disappointment . . . a disruption of hopes . . . and bonding in hate results."

Holman and Kanwar (1975) studied the obstetric histories and

early months of 28 abused children. Several significant factors emerged: prematurity, low birthweights, poor care of the child, prolonged separation of mother and child, illness, and undesirable home environments.

An infant with feeding or sleeping difficulties, or colic (Borgman, 1979), can be a trial for even the most secure mother; excessive crying in the early months causes pressure on the family, and abuse may result if the crying must be stopped at all costs. This is a warning sign of severe disturbance in the parents (Kempe, 1978).

Neurological Disorders

Permanent damage to the brain is a common result of physical abuse. Of Kempe's (1972) study group of 45 abused children, 43% had abnormality on follow-up neurological examination. Two-thirds of these children had obvious findings, including hemiparesis, focal signs, optic atrophy, and pathological primitive reflexes. The other third were found to have more subtle signs, including the various "soft" neurological findings of the child with "minimal brain disfunction." Of the 18 children with neurological disfunctions, only about 50% had a history of skull fracture or subdural hematoma, suggesting that brain damage may result from less dramatic trauma.

Martin et al. (1974) looked at 58 children five years after treatment. The sample included many children far less severely abused than usual for child-abuse studies. Martin found neurological abnormality in all but five of this group. Eighteen showed abnormalities severe enough to handicap them in their everyday lives. Again, nearly half of these children showed no sign of head injury, but nonetheless showed signs of neurological damage. Severe shaking can damage the brain without any detectable marks on the head. Also, children abused while already failing-to-thrive were likelier to be neurologically impaired than those abused while well-nourished. Kempe (1978) summarized the findings pertaining to neurological impairment: 20 to 50% of abused children are significantly damaged. In examining the intellectual and psychological effects of abuse and neglect, these neurological underpinnings must be kept in mind.

Retardation

Of Kempe's (1972) study group, 33% were functioning below an intelligence or developmental quotient of 80. Kempe's date clearily showed the strong relationship between central nervous system insult and residual retardation: 93% of the retarded children had a history of severe head trauma and/or continued to show abnormality on neurological examination. It is important to note that data from Kempe's study group were collected after intervention had taken place. A much higher percentage of retarded functioning was observed when the children were first admitted to hospital. "This suggests then that retardation might well be a permanent sequela if identification, and intervention had not taken place."

Kempe also noted that with effective intervention, 8 children with damage to the central nervous system were functioning in the normal range of intelligence. Further, even in those children who were still retarded, considerable improvement in motor abilities, language, and mental function had been afforded with proper intervention.

Chase and Martin (cited in Kempe, 1972) have presented the fact that permanent retardation can result from undernutrition in the first year of life. Fourteen (33%) of Kempe's study group demonstrated failure-to-thrive, in addition to physical abuse. Failure-to-thrive occurred twice as frequently in the children who were still functioning retarded, as in those with subsequent normal mental function. Undernutrition in the physically abused child may be considered a form of "passive" abuse coincident with "active" abuse. In those abused children who were also found to be neglected, undernourished, and poorly cared for at the time of identification, there was a higher risk of serious permanent effects than those abused children who had adequate physical care. More active intervention is thus required.

Delayed Motor and Language Development

Deficits in motor development are associated with the permanent neurological impairment. Among Kempe's study group, a large number of the children were observed with absent, minimal, or im-

paired speech and language. Even after intervention, there were 16 children (38%) with developmental delays in language. Of these children, 75% were of normal intelligence. An even greater number had impaired language before treatment and showed accelerated development in speech and language skills as a result of early intervention.

The high frequency of language deficits among maltreated children may be based in part upon the extreme vulnerability of language as a nervous system process. Phylogenetically, it is one of the human being's most advanced cognitive processes. It is often selectively impaired regardless of etiology. Among severely deprived children, there is typically a paucity and concreteness of language.

According to Kempe (1978), delays in motor, social, cognitive and speech development are common by one year of age. Retardation is related more to the emotional deprivation and neglect than to physical abuse.

Behavioral Extremes.

Morris et al. (cited in Kempe, 1972) outlined the typical behavior of a battered child upon hospitalization. Most of these children do act differently from their nonabused peers. Common behaviors include: crying very little in general, but crying hopelessly under examination and treatment; do not look to parents for assurance; show no expectation of being comforted; are wary of physical contact; apprehensive when other children cry; and are on the alert for danger and continue to size up the environment. This is in contrast to nonabused hospitalized children who cling to parents, and turn to them for assurance.

Lakin (1977) included the following behavioral descriptions in a training manual for Head Start personnel. Abused or neglected children: 1.) exhibit behavioral extremes, e.g. crying often or crying very little and showing no expectation of being comforted; being excessively fearful, or seeming fearless of adult authority; unusually aggressive or destructive; or extremely passive and withdrawn; 2.) some are wary of physical contact, especially when initiated by an adult; some are inappropriately hungry for affection, but have difficulty relating to peers and adults; 3.) they may ex-

hibit a sudden change in behavior, e.g., regress to behaviors such as thumb-sucking, bed-wetting; become suddenly disruptive, or extremely withdrawn; 4.) learning problems that cannot be diagnosed, partly from lack of ability to sustain attention, or excessive self-absorption.

Developing Personality Patterns

Malone (cited in Kempe, 1972) extensively studied the behavior of 21 preschool children living in disorganized families, particularly as their behavior revealed an adaptation to danger in their environment, i.e., abuse from their parents. He described four interrelated characteristics of abused children: 1) danger orientation: distrust, tension, guardedness; 2) visual and auditory hyperalertness: constant visual and auditory scanning of the environment (later described by Kempe, 1978, as "frozen watchfulness"); 3) use of avoidance and denial to unpleasant and anxiety-producing situations. 4) hypertrophied (under-developed) ego functions. While these traits serve the child in adapting them to a hostile environment, they are detrimental to learning and personality development in the long run.

Yates (1981) noted that the behavioral traits of 50 abused children whom he observed in a pediatric ward, ages 2 weeks to 6 years, all of whom "have been exposed to a caretaker's murderous rage." These characteristics fell into three major catagories, which he labeled, "destructive," "frightened," and "private."

The destructive child is extraordinarily irritable, demanding and angry; requires constant supervision, because he destroys property, disobeys rules, and inflicts injury upon other children. Parental contacts elicit screams, recriminations, and violent displays of affection. Other characteristics include limited ego functions; rudimentary overall functioning; "hyperactivity", ie., restlessness and impulsiveness. The destructive child is more likely to be male. These children comprised 25% of Kempe's (1978) sample (he called them "demons.")

The destructive tendancy demonstrates an overt identification with the aggressor. The behaviors are caused by the child's repeated frustrations at getting basic needs met. In effect, the

child is also revealing adaptive behavior, by seeking to provoke the needed attention with whatever behavior it takes to get the attention, even if it is negative. These are the children who regularly elicit abusive fantasies in caretakers, and are most likely to suffer subsequent abuse, and serial failures in foster care. Older destructive types also display tendancies toward fire-setting, regressive rages, vandalism, cruelty to animals and people, school underachievement, and juvenile delinquency.

The frightened child comprises most abused girls. These children are withdrawn, anxious, and passive. They avoid contact with others. Their overly compliant, undemanding behaviors are aimed at maintaining a low profile, avoiding any possible confrontation with a parent which could lead to abuse. Again, the behaviors reveal an adaptation to a cruel, unpredictable environment, by trying to avoid any behavior which can be noticed. In many of these children, there is an avoidance of eye contact, as if there is safety in a kind of invisibility. These excessive constraints on the natural tendancies of young children to explore and interact with others and their environment, leads inevitably to deficits in cognitive and ego functions, general immaturity, attentional deficits, and underachievement. Other commonalities include picky eaters, compulsive stealers, and fussy, obstinate behavior.

Kempe (1978) described how the obediance of these children is replaced by a growth in assertiveness and resistance when the child is removed to a more permissive environment. This child may be stoic at first, and it may take days to show her hurt and loneliness. These children appear to be extremely sensitive to criticism and rejection, however mild. "Harshness causes a quick return to frozen watchfulness and withdrawn mistrust. Anger may be pent up and come out in play with smaller children."

The third and most subtle behavioral category is Yates' (1981) private child. These children display precocious ego functions in some areas, and alarming deficits in others. These children may be pleasant, attractive, and seem very bright. They can learn roles, routines, and sources of nurturance very quickly, learning how to appropriately manipulate various caretakers, in order to meet their needs. Some have far advanced cognitive skills, in certain areas,

e.g. visual cues, and understanding the subleties of interpersonal relationships. They may have good frustration tolerance, attention span, impulse control, and ability to sublimate in autonomous activity.

However, this child has poor peer relationships, and cannot form affectional ties. The child's total psychic energy is tied up in attempting to please adults. As an infant, there is an alertness and a "studying" attitude toward adults, which can be clearly identified in the second year of life. The child quickly assesses a parent's mood and needs, and acts accordingly. There may be a role reversal with the parent. The parent inappropriately turns to the child to meet his/her needs, and the child may become prematurely adult, even attempting to meet a parent's physical needs. This is the type of child at risk for sexual abuse. There is a fluidity to the child's ego, an "as-if" quality that "nothing really matters anyway". According to Yates, the child's "charm and precocity mask the emptiness within." Because of their extraordinary coping abilities, this child is often not recognized as having difficulty, nor is referred.

Regardless of personality configuration, abused children commonly share the traits of unpredictability and disorganization. It is more difficult for these children to distinguish reality from fantasy. They experience great difficulty in recognizing their own feelings, especially joy, and take little pleasure in themselves. They typically think of themselves as worthless, unlovable, and stupid. Bender (1976) indicated the compulsive need of abused children to provoke punishment from everyone with whom they come into contact. He attributed this to a sense of guilt resulting from the intense anger and aggression toward the abusive parent. Wald (1961), Green (1968), Lester (1972), and Money (1972) indicated other severe behavioral symptoms of abuse and severe neglect: self-mutilation, preceded by head-banging, among them. It is thought that this type of behavior is a means for the child to establish the missing tactile contact so desperately needed. Following removal to more therapeutic environments, these severe symptoms are typically reversed.

The older child is often quick to find fault in other children

and to prescribe severe punishment. They are punitive and rigid, with the kind of conscience more concerned with the forms of behaviors, than their moral significance. Some older children are depressed to the extent that they commit suicide. They believe that they have relieved their parents of the burden they believe themselves to be. Babow (1974) revealed the connection between abuse and later suicide attempts.

Effects on Schooling

Maltreated children enter school with great disadvantages. Some of the developmental delays may be made up in part when the child is exposed to the ordered and stimulating environment of school, especially if s/he is not criticized and is supported. The child may perform well enough to get by, but not at the level of his/her true ability. Having learned inappropriate coping styles in adapting to their abusive environments, and disorganized by anxiety, the child may not risk disapproval by giving the wrong answer. They may give up quickly and not try. Others may be so vigilant to the demands of the teacher, that they cannot attend well to the task at hand.

Preoccupied with extremely negative pictures of themselves, the school age child may become more and more of a behavior problem at school. Parental explanations that they punish their child because s/he is incorrigible may even be accepted by others as understandable. That abuse itself has created the problem may not be considered. School personnel, frustrated by the child's lack of response to a caring, concerned attitude, may also give up, and further complicate the problem. Hagebak (1973) contrasted the Dallas schools, where corporal punishment is permitted, with other districts with rules against it. He found that schools practicing corporal punishment have more behavioral problems than schools not employing it. Corporal punishment tends to frustrate children and make them more hostile and apathetic.

Adolescence

Adolescents typically cover up the problem at home, and may even run away, but without seeking help from community services.

Some adolescents begin to express their anger in delinquent behavior. Belonging to a gang gives the adolescent the feeling of being wanted. S/he is rewarded for discharging pent up aggression through violent means, or drug and alcohol consumption.

Steele and Hopkins (1965) found that of 100 adolsecents brought to a juvenile detention center for the first time, 84 had been neglected or abused before age 6. In addition, from the total, 92 had been mistreated or sexually abused in the previous 18 months.

Bowley (1947) connected the experience of being an unwanted child with later feelings of inferiority. This led to behavior problems, such as stealing, in his view. Rutter (1972) connected delinquency to "maternal deprivation" during infancy, as well as to discord in the family.

In a study commissioned by the New York State Assembly, Select Committee on Child Abuse (1978), a large number of children from 8 counties in the state were studied longitudinally from records beginning in 1950, through 1972. One group consisted of 5136 children in 1423 families, and another, 1963 children. The findings demonstrated a significant empirical relationship between child abuse and neglect and later juvenile delinquency and ungovernability. Among the findings were the following:

1. 50% of the families reported for child abuse and neglect had at least one child later taken to court as delinquent or ungovernable. In Monroe County, where the records were most complete, the rate was 64%.

2. In Monroe County, the rate of later delinquency or ungovernability among the children reported earlier as abused or neglected was five times greater than among the general population.

3. Delinquent children who were reported as maltreated earlier tended to be more violent than other juvenile offenders.

4. Few services were provided to abused or neglected children and their families. In the 1950's, less than 7% of child protective contacts led to services. In the 1970's, 12% of CPS contacts led to supervision of the parents; 1.2% led to other services. Most of the founded child protective contacts ended in no action.

5. The placement rate in child neglect was higher than in abuse,

indicating that it is a more intractable problem.

6. Children found in the reportable categories of the study came from similar family structures, and were significantly different from the general population. The families were often multi-problem, disfunctional, and isolated from the community.

Teen-age pregnancy is another legacy of child abuse. In adolescence, the unmet needs for love and acceptance become more acute. The deprived adolescent finds a kindred spirit of the opposite sex, with similar needs for acceptance. "Searching for love at any price, these young people do not look too carefully at what is expected in return." (Kempe, 1978) The burdens of early pregnancy, and perhaps marriage, are overwhelming for a parent who is little more than a child herself. Marriage and parenthood become just another dead end. As previously noted, the mothers of failure-to-thrive infants were typically very young, and unprepared for the responsibilities of a child. Thus the cycle continues.

THE ABUSIVE PARENT

The potential for abuse has been linked to three major factors (Kempe, 1972): 1.) parental factors; 2.) child characteristics; and 3.) a crisis or series of crises which act as precipitating factors.

"The parent's childhood loads the gun; present life conflicts cause the parent to raise it; the child phase - specific needs help to pull the trigger." (Gil, 1970)

The abusive parent cannot be stereotyped: there are no common psychological patterns yielding a psychiatric diagnosis. Fewer than 10% of seriously abused children have parents who can be diagnosed as mentally ill, e.g., psychotics or psychopathic. However, there are some commonalities among parents who abuse or neglect their children that emerge from the literature: 1.) unfulfilled needs for nurturance and dependence; 2.) fear of relationships; 3.) lack of support systems; 4.) marital problems; 5.) life crises; 6.) inability to care for or protect a child; 7.) lack of nurturing child rearing practices.

Many abusive parents were themselves deprived of nurturance, and emotional support as children. These unmet needs for love, support, and feelings of competence are carried over into adulthood, and continue to shape relations with family, friends, and especially, children. Abusive parents have not learned to identify and obtain the emotional support they need from others, nor have they learned how to cope with the rage and fear, and frustration resulting from their unmet needs. This leads to interactions with their children in which there are exaggerated demands for parental gratification. The child, unable to meet these expectations, may be punished excessively (Pollack and Steele, 1972).

In addition, since these parents were themselves abused, they tend to accept extreme forms of physical punishment as the norm. Punishment inevitably leads to further behavior problems in the child, thus evoking more and more extreme reactions from the parents. A downward spiral of deteriorating relationships is the result. Without outside intervention or support from others, there appears to be no way out for the individuals caught up in this very desperate situation. Since the abusive parent is frequently socially extremely isolated, there is no one to turn to. When outside individuals such as caseworkers attempt to bridge the gap, they are typically met with mistrust and either active or passive sabotage of their efforts to help. These parents may be uncooperative at first and only later show their desperate desire for closeness with the worker, but their simultaneous terror about it.

Abusive parents have been found to have unrealistic expectations of a child's developmental abilities. They tend to view infants and children as if they were much older than they are, and possessing much greater intellectual and physical abilities than they actually have. In their misperceptions, the parent wrongfully endow the child with the ability to either understand and meet parent expectations, or to intentionally frustrate them, long before this is developmentally possible for the child. The special child - one who is premature, or developmentally handicapped, or in some ways requires extra parental attention - is especially at risk for abuse. The child's differences may arouse resentment and disappointment in the parents, and in addition, may fail even more than the normal

child to live up to their parents inordinately high expectations.

Gil (1970) represented the abusive parent's strong reliance upon projection as a psychological defense mechanism. The parent attempts to cope with intolerable internal conflicts by means of externalization, using a particular child as an unconscious projection of himself. The child is the scapegoat for the parent's unconscious sense of self-hatred and guilt. The parent, in essence, relieves a part of his/her intrapsychic stress and need to punish themselves by projecting their self-hatred upon the child, and exorcizing it through severe punishment.

Various authors have shown that potential abusers would be far less at the mercy of their own internal conflicts, if their environment were to provide a greater degree of satisfaction, support, and alternative modes of expression. The overwhelming burdens of poverty, illness, social isolation and discrimination, housing problems, marital discord, and constant external stresses are the social heritage of these families. Merrill (1962) found that of 115 families seen at a child protection agency, 90% had serious social problems: marital and financial.

INTERVENTION AND TREATMENT

This discussion will concentrate only on intervention with the infant and preschool child. There are five main reasons for this:

1.) The infant and preschool child are far more vulnerable to abuse and neglect than other children. More occurs among children of this age, and the effects are most devastating. It is now well known that the first five or six years of life are critical for later functioning.

2.) Without treatment before age six, earlier behavior patterns continue, but in a more aggravated form (Kempe, 1978).

3.) Developmental delays can more likely be ameliorated, and the child prepared for greater success in school, following early intervention.

4.) A potentially greater effect is possible with early intervention. "The parents' progress is always slow, whatever the

circumstances, but the children's, if they are treated early, is often remarkably swift and profound." (Kempe, 1978)

5.) Studies of successful parent re-education and therapy programs have shown that parents learn to understand and enjoy their children more. Later arriving siblings can also benefit from these positive changes in the family.

Casework is Not Enough

No statement speaks more insistently to the urgent need for services for the abused and neglected child than the following: most children who die as a result of abuse do so in families already under the care of the court or a child protection agency. (Kempe, 1978). While casework is essential for the identification of the problem, it is clear that casework alone cannot solve it. Child protection workers do not have the time nor adequate training to deal with the multiple emotional and developmental problem of children. And since case workers are enforcers of the child-protection laws, their role does not allow for the development of the trust required for a counseling relationship with the parents. Turn-over among case workers in CPS is very high, at least 50% each year.

Treatment Overview

There is no such thing as a standardized program of treatment for abusing families. At the present state of knowledge, treatment plans are based on arbitrary factors such as the perception of family needs by physicians and caseworkers and the availability of resources in any given community. It has been shown, however, that most families have been better able to cope with their problems and are less likely to maltreat their child, when they receive supportive treatment services (Lakin, et al., 1977).

Kempe (1981) argued that the treatment offered a child must be related to the treatment potential of the family as a whole, yet must care for the child's specific needs as well. Her recommendations were as follows:

1.) The intervention must begin at the time of crisis, in order to establish a therapeutic relationship with the family, and to obtain the best assessment possible.

2.) If termination of parent rights is to occur, the child should be permanently placed as soon as possible, in order to provide continuity with a parental figure. The child must be given the opportunity to "say goodbye" to his family, through treatment that recognizes the child's need to grieve, and to express his anger, and fears. Treatment must also help the child adjust to the new living situation, with its different expectations and opportunities.

3.) If the child is to be placed temporarily in a foster home or group facility, with eventual return home if possible, the focus of treatment must be preparation for an early and permanent return home. Kempe recommends an "enriched foster care program," which consists of the following elements:

a.) carefully selected mature foster parents, who not only provide care for the child, but also friendship, support, and modeling of parental roles for the child's own family;

b) visits with children are combined with group treatment for parents;

c) individual family-interaction treatment sessions in a parent center;

d) professional and peer support for the foster parents;

e) a firm time-limit to foster care. The benefits of this are to reduce the uncertainty of custody in the minds of all concerned, particularly for the child, for whom a few months may seem an eternity. Another benefit of insisting on a predetermined end is to reduce resistance, and to mobilize all parties concerned to set attainable goals, and to get down to work on specific parenting issues.

4.) If the child is to remain at home, the treatment goals are two-fold:

a) to improve parenting and encourage positive bonding among family members; and

b) to help the child deal with developmental and emotional problems.

The parents' needs must be integrated into the program for the child, for if the child alone receives treatment, the parents' unmet needs for nurturance may cause them to sabotage therapy efforts. Therapy must not criticize or alienate the parent, but integrate him/her into the process of helping.

Working with the Infant

Kempe (1981) recommends concentrating on supporting the mother of the infant, providing her with some experience of empathic nurturance for herself, through one-to-one work with a lay therapist or home health visitor. Training also includes encouraging her recognition of the infant's needs, and her pleasure in his/her increasing responsiveness to her. The infant stimulation training includes demonstrations of ways to nurture the child, and to encourage his/her physical and cognitive learning and social competence.

During periods of family crisis, in which the relationship of mother and infant is especially vulnerable, an emergency "respite home" or "crisis nursery" should be available round the clock, with maximum flexibility. Prolonged, formal child placement can thus be avoided, in the best interest of the child.

Kempe (1978) described in detail an "early warning system" for preventing child abuse and neglect, by predicting those parents likely to have parenting difficulties, through observation of their behavior surrounding the birth of their child. The study showed that physicians and others can accurately predict high-risk families through interviews, and observations of parents in the labor and delivery process, and of parent-child interactions during the first six weeks. A number of "danger signs" were isolated, such as parents who had made no preparations for the arrival of the child, and mothers who avoided eye-contact with their newborns. High-risk families were then divided into two groups by the amount of active intervention they received which was intended to counteract the potential for abuse. The techniques included assigning a home health visitor, or referral to a mental health agency. The study found that these types of early intervention were highly effective. Only the high-risk, non-intervention families were later involved in reports to CPS, foster care, or hospitalization for failure-to-thrive, despite the matching of the two groups preceding intervention. No child in either the low-risk or high-risk intervention group was hospitalized for abuse or neglect; 5 high-risk, non-intervention children needed hospital treatment for serious injuries. The short and long-term costs of the five injured children were estimated at $1 million, as opposed to the extra costs for the 50 in the high-risk intervention group which amounted to $12,000.

The type of observations made were "not difficult" and should be a routine part of all pediatric care, according to Kempe.

Locally in Monroe County, the PACT Program at Strong Memorial Hospital is involved with just this type of early intervention and training of physicians to recognize high-risk patients.

Treatment of the Preschool Child

Treatment of the preschool child is usually best placed in daycare or nursery school programs, to supplement the lack of stimulation and nurturing at home. According to Kempe (1981), the program must be integrated into the parents' treatment, as well as with other specialized services required by the child, such as play therapy, or speech and language habilitation.

When a therapeutic preschool is not available, a regular preschool can place a few of these children, if consultation and training is available to staff. Crisis intervention must also be planned for.

"The treatment goals of the preschool or therapeutic daycare center are to provide the child with a consistent, safe, nurturing environment, which is sensitive to the responses and needs of the child . . . Validation of the child's feelings, acceptance of his individuality, help in modifying behavior, and negotiating relationships all lead to increased self-esteem, and social competence. The encouragement of cognitive skills and problem-solving lead to self-confidence; the sharing of play by staff and children lead to pleasure and increased freedom." (Kempe, 1981)

The therapeutic playschool provides a safe, predictable environment, where the child is allowed to build trust through firm routines, and warm acceptance. Gradually he gains more control over his behaviors. It does for the child of 3 years what an ideal mother would have done at 18 months: interprets in words the child's simple activities and interactions, helping him turn them into experiences that can be understood. He experiences the full attention of adults, and his feelings, by being stated explicitly, are validated. His developmental delays are overcome through appropriate stimulation and training, as well as appropriate specialized services.

Individual play therapy may or may not be a part of the program

(Davoren, 1979; Kempe, 1978). The more severely withdrawn or aggressive child may require the greater intensity and specific attention of the one-on-one, as well as the opportunity to act out his feelings, uninterrupted by other children.

A daycare, nursery, or Head Start center can also serve as a valuable resource for respite and support for the parents, as well as stimulation, validation, and safety for the child. In the White House Conference on Families, it was noted that the "vast majority can be treated by professionals and paraprofessionals working in settings not primarily established for the treatment of mental health."

Also, "It is effective to use professional subspecialists as consultants to preschool/daycare programs because remediation may be provided best in such a setting." (Martin, 1979).

Combination of Services

Armstrong (1981) reported on the progress of 46 at-risk families and their 74 preschool children where intervention was provided, as compared to a similar group with no intervention. Intervention consisted of three services, in which all families were expected to participate: Home-based counseling, Family-School (therapeutic preschool), and Neighborhood Peer Support Groups. The families participating in the program were found to:

1) reduce stresses from 7 to 4 on a profile;
2) achieve 84% of family goals;
3) improve conditions of child-care in the home;
4) have children improve on a mental development index an average of 6 points, from 98 to 104 IQ. Families were most successful if they participated in all three services; spent more time in the program; were older; and were from a higher SES group. The program successfully intervened in an at-risk group while the children remained in the home, thus avoiding costly and traumatic out-of-home care. Armstrong reported that the treatment program was highly replicable, with other agencies and populations.

The Mt. Hope Family Center in Rochester provides this type of comprehensive program. Presently licensed for 40 children as a day treatment setting, the center was opened three years ago. It serves children ages 3 to 5, and in a year, experiences a 75%

percent turn-over of clients, who stay on the average of a year. According to an interview with Craig Twentyman, the director, the staff are now involved in an evaluation of the results of their intervention. He estimated that without this type of intervention, about half of the children would not be placed in regular classes in school; they would be placed in special classes in the schools or in other institutions. With their intervention, most of the children are placed in regular classroom: of one "graduating class" of 19, only two children required a special education class placement following their program.

Crisis Intervention

Treatment begins from the first day that the family reaches out for help. Crisis, by its very nature, provides a major opportunity for change (Borgman, et al., 1979). The intervenors's role, if at all possible, is to make a painful confrontation possible with the parents: "this crisis is your doorway to change." The crisis is not only a threat, but a challenge for the family to mobilize its energies and resources to deal with the problem, and to see the potentials for developing their competence to better cope in the future. If this is not possible, however, the first priority is to protect the child.

The primary goals of crisis intervention are:

1.) to insure the safety of the child;

2.) to terminate the crisis as effectively as possible, to reduce the painful and disfunctional emotional responses standing in the way of change;

3.) to help the family regain or develop their abilities to handle this situation and future situations effectively on their own.

Foster Care

Foster care is the most common alternative to home care utilized by CPS. According to Martin (1979), "The legitimate use of foster care as a short-term, crisis oriented adjunct to treatment becomes highly questionable when the placement stretches into weeks, months, and years . . . The turn-over in foster homes, the questionable quality of many foster homes, and the trauma to children of being raised by "temporary" parents all speak to the impor-

tance of finding alternatives to long-term foster care."

The following were cited as appropriate uses for foster care:
1.) a short-term living arrangement for children in emergency situations, until an investigation of the family and home can be made, and a treatment plan established;
2.) a diagnostic placement, to determine if the child's physical growth or development accelerates under proper conditions. In failure-to-thrive, determination can occur after only two weeks, and rarely requires more than six months to observe changes.
3.) a therapeutic milieu, by providing something especially beneficial to the child. Martin emphasized that this is not a holding action, providing a place for the child to wait, while the adults make up their minds about placement. The use of foster care as therapy requires foster parents who are trained and supported as therapeutic agents for the child.

A well-structured treatment plan should be instituted immediately after placement. This provides the parents a contract regarding what is expected of them, what professionals will be working with them, and what services will be provided to facilitate return of the child.

Foster care is unacceptable when it is intended to provide a substitute home for a long-term period, especially for very young children. Communities must provide alternative to foster care, if the best interests of the child are to be served.

Services for Parents of Abused/Neglected Children.

The literature is in general agreement that approximately 10% of abusive parents are very seriously emotionally ill, and probably cannot be helped. Severing parental rights must be seriously considered in these cases. Among the parents involved are the following groups (Kempe, 1978):
1.) delusional psychotics, in whom the child is a symbiotic extension of the self;
2.) aggressive sociopaths, "committed only to bashing,"
3.) "cruel" individuals who subject children to premeditated torture; and
4.) fanatics.

The remaining 90% are potentially treatable. Another 10% may

try treatment and fail, leaving 80% with a good prognosis. This is the success rate experienced in Colorado, with the Kempe program: parents experiencing treatment over a period of 9 months are reunited with their families with no further injuries.

Psychotherapy

Psychotherapy for abusive parents may be beneficial, if it specifies goals and does not consist of intensive work to uncover long-standing needs. Typical goals include:

1.) relating more comfortably with other adults;
2.) improving practical realities of the living situation;
3.) improving intimate relationships.

Therapy involves the entire family, if possible.

Specific services, such as counseling for drug and alcohol abuse, budget counseling, marital counseling, etc., may be recommended.

Programs have found that the traditional professional distance, the assumption that, "if people want help, they'll show up," does not work well with abusive parents. "Reaching out" to families, for home-visits, etc., is necessary for success, and something "every system has to learn." (The Community Team, 1975)

Green et al. (1981) found that patients who were provided supplementary home-visiting and service-oriented telephone advocacy, fared better in treatment than patients receiving out-patient counseling alone. Outreach is a "pivotal component of child abuse intervention." This study, undertaken in an economically deprived and predominantly minority, inner-city population, also found that personality factors of the parents were important. They also found that parents who received early therapeutic intervention, before they had a chance to become ingrained in patterns of abuse, were most often successful. In summary, the authors stated: "Our study confirms the feeling of many who believe that the majority of abusive parents can be helped to curb the violence and to improve the quality of their child-rearing."

Parent Education Groups

The goal of this type of group is informational as well as support for the parents, and may include (Barnett, 1980):

1.) basic education about the stages of child development, behavior, and developmental skills;
2.) modeling behavioral alternatives when setting limits, disciplining the child, coping with feelings, etc.
3.) a support group which allows parents to share both frustrations and solutions, and which demonstrates to them that their problems are not unique;
4. an opportunity for observation of the child and reinforcement of positive parent-child interactions;
5.) positive experiences for the parents, such as field trips;
6.) activities to implement at home and to report back to the group.

Self-Help and Support Groups

The peer support offered in these groups helps to reduce social isolation, and to create an atmosphere of sharing common problems and solutions. Parents experience relief in realizing that they are not alone in their frustrations with parenting, and may learn from their peers with many fewer defense mechanisms operating, than from the "experts" or the "professionals". The group becomes a surrogate family where the closeness enables parents to be nurtured and to learn to nurture others. A group consultant is generally available to intervene during a crisis. Parents Anonymous is a prime example of this type of group. It was founded in 1970 by an abusive mother, and now has grown to an organization with 850 chapters around the world.

Parent Aides

These include visiting homemakers, lay therapists, and in our area, Visiting Friends. The individual serves as the parent's ally, and is not responsible for the child's safety. "The parent aide becomes intensely involved with the parents, providing them with warmth, understanding, support, and a listening ear." (Martin, 1979). The individual involved must encompass a great capacity for empathy and understanding, as well as maturity, and a sincere desire to help.

Signs of Change

Behavioral changes become apparent when the child begins to respond to intervention. Although these changes do not always occur, following 3 to 6 months in foster care or alternative day programming, a period of tremendous growth in development may occur. There are a number of personality precursors that signal a later gain in the acquisition of developmental milestones. These precursors are apparently essential prerequisites to learning, and include: increased attention span; a new willingness to imitate; increased interest in people; disappearance of apathy; increased interest in age-appropriate problem solving and investigation of the environment; positive response to praise; appropriate use of toys; and higher motivation. In another 3 to 6 months following the appearance of these positive behavioral signs, a developmental acceleration on test-scores and other observations may become apparent.

Concerning the parents, Kempe (1978) has outlined four behavioral changes which, once confirmed, strongly indicate that the children in the family will never be injured again. These include:
1.) the abusive parent's image of him/herself improves to where s/he has made at least one friend with whom s/he shares enjoyable experiences on a regular basis;
2.) both parents have found something attractive about their child and show him/her outwardly;
3.) both parents use lifelines of professional help in crises;
4.) reunions with the child, if in foster care or hospital, have improved, and the increased responsibility of a child does not strain the family.

While the family may continue to need years of support, this is far better for all concerned than foster care. Kempe (1978) has demonstrated from his clinical experience that approximately 40% of formerly abusing parents do grow and develop emotionally and can nurture their children. Another 40% stop physical, but not emotional abuse.

The current picture of child abuse and neglect is not a hopeless one. Many children and their families have been helped to become more successful, loving, and better adjusted through the various forms of prevention and treatment outlined here. Now that the problem is no longer invisible, we must move beyond mere identification, to the confident and consistent use of early

intervention. It has been shown that aggressive programs of treatment, when started within the first few years of a child's life, significantly prevent damage to the child's later emotional well-being.

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